DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION CENTER FOR SUBSTANCE ABUSE TREATMENT

Form Approved: OMB Number 0930-0206 Expiration Date: 09/30/2006

ı	CENTER FOR SUBSTANCE ABUSE TREATMENT	See OMB Statement on Reverse
	Exception Request and Record of Justification Under 42 CFR § 8.11 (h)	DATE OF SUBMISSION:
		atient exceptions in opioid treatment programs (OTPs) under 42 CFR § 8.11 (h).
	Detailed INSTRUCTIONS are on the cover page of this form. PLE a speedy reply. Thank you.	ASE complete ALL applicable items on this form. Your cooperation will result in
	Program OTP No: (Same as FDA ID)	Patient ID No:
FOR CHANGE BACKGROUND INFORMATION	Program Name:	
	Telephone: Fax:	E-mail:
	Name & Title of Requestor:	
	Patient's Admission Patient's of dosage lev	
	Patient's program attendance schedule per week (Place an "X" next to all days that the patient attends*): *If current attendance is less than once per week, please enter the sc	M T W T F S chedule:
	Patient status: Employed Home	maker Student Disabled
	Other:	
	Nature of Request: Temporary take-home Temporary change in Detoxi medication protocol except	ification tion Other:
	Decrease regular attendance to (Place an "X" next to appropriate days*): S M T W T F S Beginning date: *If new attendance is less than once per week, please enter the schedule: Dates of Exception: From to # of doses needed:	
ST F	Exception.	# Of doses fieeded.
REQUIREMENTS REQUEST	Justification: Family Emergency Incarceration Step/Level Change Employment	Funeral Vacation Transportation Hardship Long Term Care Other Residential Medical Facility Treatment
	Homebound Split Dose	,,
	Other:	
	Regulation Requirements:	
	For take-home medication: Has the patient been informed of the dar	ngers of children ingesting methadone or LAAM? Yes No N/A
	For take-home medication: Has the program physician determined to determine whether the patient is responsible enough to handle methors.	If that the patient meets the 8-point evaluation criteria Yes No N/A hadone as outlined in 42 CFR §8.12(i)(2)(i)-(viii)?
	 For multiple detoxification admissions: Did the physician justify massess the patient for other forms of treatment (include dates of detoxification). 	
	Submitted by: Printed Name of Physician	
	Printed Name of Physician	Signature of Physician Date
_	State response to request: Approved Denied	State Methadone Authority Date
Ž V	Explanation:	
APPROVAL	Federal response to request: Approved Denied	
⋖	- Franchiscon	Public Health Advisor, Center for Substance Abuse Treatment Date
	Explanation:	

Please fax to CSAT/DPT at (240) 276-1630 or Email: otp@samhsa.hhs.gov

This exception is contingent upon approval by your State Methadone Authority (as applicable) and may not be implemented until you receive such approval.

Purpose of Form: This form was created to facilitate the submission and review of patient exceptions under 42 CFR § 8.11(h). This does not preclude other forms of notification.

Paperwork Reduction Act Statement

Public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0206); Suite 7-1043, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0206.

FORM SMA-168 (BACK)